

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Infinia at Owatonna
Survey Exit Date: October 18, 2007

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on January 22, 2008. The record of the Office of Administrative Hearings (OAH) closed at the conclusion of the IIDR conference that day.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, Division of Compliance Monitoring (Division), P.O. Box 64900, St. Paul, MN 55164-0900, appeared for the Division. Mary Cahill, Department of Health, also participated in the conference.

David Grant, General Counsel, Infinia Healthcare Companies, LLC, 450 S. 400 East, Suite 200, Bountiful, UT 84010; Bev Bauer, RN Director of Nursing, and Mary Ann Higgins, Activity Director/Fall Committee Member, 201 Southwest 18th Street, Owatonna, MN 55060, appeared for Infinia at Owatonna (the facility). Patricia Howell, RN Consultant, Health Information Consulting, 4538 South Tanglewood Drive, Holladay, UT 84117, also participated in the conference.

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

FINDINGS OF FACT

1. On October 18, 2007, the Division issued a Statement of Deficiencies to the facility, citing violations of Tag F323 (quality of care, provision of an environment that remains as free as possible from accident hazards and provision of adequate supervision and assistance devices to reduce the risk of

falls). The Division found deficient practices with regard to Residents # 6, 15, 5, 10, 1, and 14.¹

2. Based on observations made during the survey, the Division also determined that there was an immediate and serious threat to resident health and safety beginning at 11:30 a.m. on October 18, 2007, with regard to Residents # 6 and 15. The immediate jeopardy continued through 3:30 p.m. that afternoon, when a corrective plan was approved.² The plan of correction required, among other things, that the facility take immediate action to update care plans, conduct staff training on the use of bed and wheelchair alarms, and ensure that a staff member was present on the nursing wing to respond to alarms when they sounded.³⁴

Resident # 6

3. Resident #6 was an 85-year-old man who was admitted to the facility in March 2005 with diagnoses of myocardial infarction, congestive heart failure, coronary artery disease, and dementia from anoxic brain injury.⁵ At that time he independently walked, transferred, and got himself into and out of bed. In August 2006, the care plan was revised to reflect that he was at risk of falling due to psychotropic drug use, unsteady gait, poor safety awareness, and history of falls. The interventions implemented at that time were to monitor for the following: unsteadiness with walking and transferring, bowel and bladder urgency, and side effects of medications. In addition, he was to have a quarterly risk assessment.⁶ On April 14, 2007, staff conducted a fall risk assessment, found him at risk for falls, and concluded staff would “[proceed] to care planning.”⁷ Although the facility appears to have implemented new interventions at this time, it does not appear that the resident’s care plan was revised to include them.⁸

4. On May 13, 2007, the resident fell in his room, hit his head, and sustained a right hip fracture.⁹ The incident report reflects that wheelchair and bed alarms were in place and working when the resident was found and that he was currently using anti-slip shoes/socks (although these interventions are not reflected on the care plan). The report also provides that obstacles were in his path, but it does not describe what the obstacles were or how the facility changed the environment, if at all, to remove the obstacles.¹⁰

5. When the resident returned to the facility after surgery and hospitalization, the care plan was revised to provide for assistance with transfers,

¹ Form 2567, Facility Exhibits.

² Exs. I & J.

³ Ex. J.

⁴ Ex. K-24b.

⁵ Ex. K-4.

⁶ Ex. K-24b.

⁷ Ex. K-20a.

⁸ Ex. K-24b.

⁹ *Id.*

¹⁰ Exs. K-31a to K-32.

referral to physical and occupational therapy, education regarding safe transfer and mobility techniques, and the use of a motion sensor on his bed and wheelchair to alert staff to the resident's need for assistance.¹¹ Nursing notes taken between May 22, 2007, and May 25, 2007, reflect that the resident continued to attempt transfers without assistance and that alarms were not always activated or responded to by staff in time to prevent the transfers.¹²

6. On June 11, 2007, the resident fell in his room at 7:15 a.m. while attempting to walk to the bathroom. The bed and chair alarms were not hooked up. The resident sustained two skin tears on his left hand. In response to this incident some type of staff education took place.¹³ A physical therapist noted that she spoke to nursing staff about having alarms on the bed and wheel chair "activated at all times as patient will need supervision with transfers for safety."¹⁴ Physical therapy was discontinued in mid-June 2007.

7. On July 7, 2007, the resident fell onto his left side at 3:30 a.m. while walking to the bathroom. He sustained a skin tear on his left hand. He was wearing socks and no shoes. The bed alarm was sounding, but staff did not respond before he fell.¹⁵ No incident report was completed, and no further investigation of this fall took place.

8. On July 14, 2007, the resident fell in his room at 2:45 a.m. while attempting to walk to the bathroom. The resident had unplugged the bed alarm. According to the incident report, a new intervention of wearing gripper socks to bed would be implemented.¹⁶ This intervention was not added to the care plan.

9. On October 7, 2007, the resident was found at 10:20 a.m. on the floor of his room. According to the incident report, this incident followed a pattern similar to previous falls when the resident was transferring himself to get to the bathroom. The bed alarm was not activated and did not sound. No new interventions were implemented to prevent future falls.¹⁷ On October 11, 2007, a nurse reviewed the incident report and noted that the resident self-transfers and shuts off alarms. The suggested intervention was "Remind res. to use call light."¹⁸

10. During the survey process on October 14, 2007, a surveyor observed the resident in his wheelchair during the early evening hours. The cable from the seat alarm to the alarm box on the wheelchair was not connected. The resident wheeled himself to the dining room to eat; he then wheeled himself back to his room, where he transferred himself from his wheelchair to the toilet.

¹¹ Exs. 26b, 27b, 28a.

¹² Exs. K-41b, K-42a, K-43a.

¹³ Exs. K-33a to K-34.

¹⁴ Facility Exhibits Resident # 6 (Physical Therapy note 6/11/07).

¹⁵ Exs. K-45b, K-46a.

¹⁶ Exs. K-35a to K-36.

¹⁷ Exs. K-37a to K-38a.

¹⁸ Ex. K-38b.

The alarm did not sound because it was not connected. A staff person then entered the room and assisted the resident to bed.¹⁹

11. On October 17-18, 2007, in response to the finding of immediate jeopardy, a number of interventions were implemented for Resident # 6. A physical therapist screened the resident and recommended continual use of alarms. A high-low bed with a concave mattress was obtained to reduce the risk of injury. A bed alarm was placed permanently at the foot of the bed, so the resident could not remove it. The wheelchair alarm was re-positioned out of the resident's sight and reach, so he could not disconnect it. Floor mats were placed by the bed, but the mats were removed after it was determined they might pose a tripping hazard. His care plan was updated to reflect these changes.²⁰

Resident # 15

12. Resident # 15 is a 93-year-old man who was admitted to the facility in 2003 with diagnoses including moderate Alzheimer's dementia and degenerative arthritis.²¹ On January 19, 2007, he was moved to a room in the 300 wing to provide "more consistency in staffing patterns."²² As of January 24, 2007, his care plan addressed the risk of falling and contained interventions including use of non-skid footwear while transferring and ambulating, monitoring for unsteadiness, and cueing resident to use the call light when needed.²³ A fall risk assessment completed on April 12, 2007, found him to be at risk for falls because of arthritis, confusion, psychotropic medication use, and balance and coordination problems. He had fallen one to two times in the prior 90 days.²⁴

13. On May 5, 2007, the resident fell in the bathroom at 10:30 a.m. and sustained a 2- by 4.5-cm lump on his head. He attributed the fall to poor vision. The incident report noted that this was not an isolated occurrence but followed a pattern similar to previous falls attributable to the resident's failing vision and refusal to accept additional help with transfers. Facility staff asked the resident's family for permission to refer him to physical therapy, which the family denied. The only new intervention suggested was to leave the light on in the bathroom at all times, but this intervention was not added to the care plan.²⁵ There are undated entries to the care plan calling for staff to assist the resident with transfers to ensure he has shoes on, and "bed/chair alarms on at all times."²⁶

14. On July 6, 2007, the resident was moved back to a bed in the 100 wing "to provide resident an independent environment."²⁷

¹⁹ Ex. K-3a.

²⁰ Ex. J-4.

²¹ Ex. L-4.

²² Facility Exhibits Resident # 15 (Room Change Notice 1/19/07).

²³ Ex. L-25b.

²⁴ Ex. L-15.

²⁵ Exs. L-27a to L-28.

²⁶ Ex. L-25b.

²⁷ Facility Exhibits Resident # 15 (Room Change Notice 7/6/07).

15. On July 13, 2007, at 10:00 a.m., the resident was found lying on his right side on the bathroom floor. The incident report indicates the resident had bed and wheelchair alarms, which sounded appropriately, and that he had a pattern of attempting to transfer without seeking assistance because of dementia. No new interventions were noted except to “continue with position alarms.”²⁸

16. On July 14, 2007, at midnight, the resident fell onto his left side attempting to get to the bathroom. He was bleeding profusely from a cut over his left eye, and he was unable to stand on his left leg. The position alarms were not in place and were not activated. The resident was sent to the emergency room, where a pelvic fracture was identified, and he received sutures above his left eye.²⁹ When he returned to the facility he was moved back to a room in the 300 wing for additional supervision.³⁰

17. On July 16, 2007, at 3:10 a.m., the resident was found on the floor in the doorway to the bathroom. He had been pushing a bedside table to assist with ambulation. According to the incident report, the position alarms were in place, but it does not reflect whether the bed alarm was turned on or sounding at the time. A new intervention of “staff training” was noted, but the content of the training is not described. Based on the recommendation of the nurse practitioner who evaluated the resident on that day, the reviewing nurse directed staff to continue with position alarms.³¹

18. On August 21, 2007, the resident fell at 9:10 a.m. while trying to get to the bathroom. The incident report reflects that the chair alarm was off. The form states that the resident’s toileting habits would be reviewed, and “staff reminded that position alarms are to be in place at all times.”³² There are no records to suggest that the review of toileting habits took place.

19. On September 22, 2007, at 1:10 a.m., the resident was found on the floor of his room. He had fallen attempting to get to the bathroom and sustained a large lump and bruise on the back of his head. The incident report reflects that the lighting in his room was poor at the time. The bed alarm was on, but it did not go off. A new bed alarm was installed. No new interventions were implemented.³³

20. On October 1, 2007, at 7:00 p.m. the resident was found on the floor in front of his wheelchair in the doorway to the bathroom. The alarm on his chair was sounding, but staff did not respond before he fell. The incident report states that the resident was on a toileting program but nonetheless attempted to use the bathroom many times on each shift. No new interventions were noted.³⁴

²⁸ Exs. L-29a to L-30.

²⁹ Exs. L-31a to L-33b.

³⁰ *Id.*; Facility Exhibits Resident # 15 (Room Change Notice 7/14/07).

³¹ Exs. L-34a to L-35; Facility Exhibits Resident # 15 (Evaluation by Mary Funk, 7/16/07).

³² Exs. L-36a to L-37.

³³ Exs. L-38a to L-39. *See also* Facility Exhibits Resident #15 (Evaluation by Mary Funk 9/24/07, no need for corrections or additions to plan of care).

³⁴ Exs. L-40a to L-41b.

21. During the survey process on October 17, 2007, the surveyor observed that the Resident's chair alarm sounded at 9:10 a.m. while the Resident was transferring himself from his wheelchair to the toilet, without assistance. The alarm sounded for eight minutes, during which time no staff were present on the wing. Not until a staff member entered the wing and heard the alarm did anyone go to assist the Resident.³⁵

22. On October 17-18, 2007, in response to the finding of immediate jeopardy, a number of interventions were implemented for Resident # 15. A physical therapist screened the resident and recommended physical therapy, to which the family gave consent. In addition, the physical therapist recommended the continual use of alarms. A high-low bed with a concave mattress was obtained to reduce the risk of injury. Floor mats were placed by the bed, but the mats were removed after it was determined they might pose a tripping hazard. The facility agreed to complete a comprehensive bladder assessment to establish a toileting schedule. The resident's care plan was updated to reflect these changes.³⁶ In addition, the facility arranged to sit the resident at the last table to be served in the dining room and to have a nursing assistant present on the floor during all meals to assist residents; in addition, the facility agreed that a staff member would be on the nursing wing whenever the resident was present to ensure that staff could respond in a timely manner if his chair alarm sounded.³⁷

Resident # 5

23. Resident # 5 is a 79-year-old man with Alzheimer's dementia and Parkinson's disease. He cannot stand or walk and is dependent on staff for all transfers. His care plan provides that he is to use a self-releasing seat belt in his wheelchair to keep him from sliding forward and help him to maintain correct posture. He was assessed as being at high risk for falls and had fallen most recently during the night when he attempted to get out of bed to look for his recently deceased wife.³⁸

24. During the survey process on October 14, 2007, a surveyor observed that the resident released his seat belt, after which an alarm sounded. A staff member came to his room, shut off the alarm, and left the room without reapplying the seat belt. The seat belt remained off for about 20 minutes, until the resident was transferred to bed with a mechanical lift. A nursing assistant told the surveyor that the Resident sometimes removes the belt when he becomes uncomfortable.³⁹

Resident # 10

25. Resident # 10 is a 77-year-old woman who has a seizure disorder and a history of depression and anxiety, for which she takes various medications. She had fractured her right ankle before admission to the facility and had

³⁵ Ex. L-3.

³⁶ Ex. J-4.

³⁷ Exs. J-4 to J-5.

³⁸ Exs. M-10, M-11, M-14.

³⁹ Exs. M-1a, M-2.

problems with her gait and balance. She has some memory problems, and she uses a walker but does not require staff assistance with transfers.⁴⁰ As of October 2006, her care plan called for the following interventions (among others) aimed at preventing injury from falls: assist with mobilities as needed, monitor for problems with transferring and walking; physical therapy and occupational therapy as ordered (discontinued June 4, 2007); assure resident is wearing eyeglasses, assure glasses are clean and in good repair; monitor medications for effectiveness.⁴¹

26. The resident was found on the floor in December 2006 and January 2007. The care plan was revised in March 2007, in response to these falls, to “remind resident to ask for assistance with socks and shoes” in the morning.⁴² The incident reports suggest that the resident was referred for a physical therapy evaluation and that pressure alarms would be used on her bed, but this intervention was not added to the care plan.⁴³

27. The resident fell five times in May 2007. On May 1, 2007, she was attempting to sit on a chair in the dining room. The incident report reflects that the facility notified physical therapy and moved a popcorn machine to make more room for the resident to maneuver around the dining table.⁴⁴ This intervention was not added to the care plan. On May 2, 2007, the resident fell in her room while attempting to stand from the side of her bed, and she was found lying on her stomach on the floor. She said that she was looking for bugs on the floor and that kids were jumping off the roof. In response to this incident the resident was referred to physical therapy, and the dosage of one of her psychotropic medications was reduced.⁴⁵ On May 7, 2007, the resident was sitting on her bed and fell off while bending over to put on her shoes. The incident report reflects that a bed alarm was in place, but the resident had disconnected it because she did not like the noise. In addition, the report indicated the Resident’s bed was in the low position, but this intervention was not written into her care plan. The reviewing nurse noted that the physical therapist concluded the resident was at increased risk for falls because she lacked awareness of personal safety.⁴⁶ On May 19, 2007, the resident stood up from a chair in her room and was using her walker to turn around when she fell. She hit the back of her head on the open drawer of a bedside table. The incident report reflects new interventions of referral for an eye exam, use of a padded undergarment, and trial use of bed and wheelchair alarms.⁴⁷ The care plan was revised only to reflect use of a padded

⁴⁰ Exs. N-14, N-15.

⁴¹ Ex. N-15.

⁴² Ex. N-15.

⁴³ Ex. N-4a.

⁴⁴ Exs. N-20 to N-22.

⁴⁵ Exs. N-23 to N-25. The resident received physical therapy five times a week from May 3, 2007, to June 2, 2007, when the therapy was discontinued. See Facility Exhibits Resident #10 (Physical Therapy notes attached to Incident Report 5/1/07).

⁴⁶ Exs. N-26 to N-28.

⁴⁷ Exs. N-29 to N-31.

undergarment.⁴⁸ On May 24, 2007, the Resident fell in the day room while getting up from the couch. The resident said she tripped on the carpet. The interventions noted on the incident report were staff training and counseling (not specified) and checking the level of the anti-seizure medication. The form reflects that the resident was currently on the facility's Fallen Angel program, although this intervention was not listed on the resident's care plan.⁴⁹

28. The resident fell twice in June, once in July, and once in August 2007. On June 12, 2007, she fell because she was carrying a radio while pushing her walker. The interventions noted were that staff would continue to monitor the resident and remind her of safety concerns.⁵⁰ On June 14, 2007, the resident let go of her walker to push another resident out of the way. She lost her balance and fell against the wall, sustaining a 12-cm scrape on her forearm. The resident was reminded to use her walker at all times and to ask for assistance.⁵¹ On July 4, 2007, the resident fell in her room while standing up from her chair. She tripped on the leg of the chair and fell onto her left side. The incident report states that staff will continue to monitor for obstacles that could be in the resident's path and remind the resident on safety. The form suggests that some furniture was moved, but it does not describe what or how, and no changes were made to the care plan. On August 23, 2007, the resident tripped on oxygen tubing between her bed and chair. She fell to her knees. No new interventions were implemented.⁵²

29. On September 8, 2007, the resident came out of her room and tripped on the doorway while reaching for the hall banister. The incident report provides that the resident would be encouraged to slow down and use a wheelchair. No interventions were added to the care plan.⁵³

30. On September 27, 2007, October 4, 2007, and October 16, 2007, the resident fell while attempting to sit on a chair. She sustained a 19- by 2.5-cm scrape on her back and a hematoma to the back of her head. No interventions or other assessments were initiated. The resident was encouraged to slow down.⁵⁴ On October 12, 2007, the intervention of "assist with mobilities as needed, monitor for problems with transferring and walking" was added to the care plan.⁵⁵ The last fall on October 16, 2007, was witnessed by a surveyor.⁵⁶

⁴⁸ Ex. N-15.

⁴⁹ Exs. N-32 to N-34. "Falling Angels" is the facility's fall prevention program. The program requires, among other things, that at least one individualized intervention be added to the care plan within 24 hours of a fall. See Facility Exhibits Resident # 10 (Policy and Procedure/Falling Angels Program). The lab results showed that Dilantin and phenobarbital levels were in the normal therapeutic range.

⁵⁰ Exs. N-35 to N-37.

⁵¹ Exs. N-38 to N-40.

⁵² Exs. N-44-N-46.

⁵³ Exs. N-47 to N-49.

⁵⁴ Exs. N-50 to N-60.

⁵⁵ Ex. N-16.

⁵⁶ Exs. N3a and N-4a.

Resident # 1

31. Resident # 1 is a 76-year-old woman who was admitted to the facility on July 10, 2007, with Alzheimer's dementia. Her cognitive skills are severely impaired, and she was semi-comatose from numerous sedative medications when she was admitted. The medication orders were changed on July 12, 2007, when one of the medications was discontinued and another reduced.⁵⁷ Initially the resident was almost completely dependent on staff for assistance with all activities of daily living, but she became more alert and active within a few weeks of admission. On July 16, 2007, she was found sitting on the floor next to her bed. Bed alarms were applied at this time.⁵⁸ In the next two days, she rolled out of bed three times after becoming agitated. On two of those occasions, position alarms were in place and sounded. Staff implemented a low bed to reduce the risk of injury.⁵⁹ On July 19, 2007, a nurse faxed a request to the resident's physician to use a concave mattress to prevent her from rolling out of bed.⁶⁰ This intervention was not written onto the care plan, and it is not clear whether the mattress was put in place. The care plan's initial interventions for preventing falls were a lap buddy to prevent her from sliding out of her wheelchair and a high-low bed with mattress on the floor to prevent injury.⁶¹ At some point position alarms were added to the care plan, but that entry is not dated. On July 28, 2007, the resident was found lying on a mat next to her bed, with the alarm sounding. No incident report was completed.⁶²

32. On August 5, 2007, at 8:00 a.m., the resident was rocking herself in a wheelchair, attempting to remove the lap buddy. The wheelchair tipped on its side. The incident report reflects that the chair alarm was on, but it does not say whether it sounded. A new intervention was proposed to add tip bars to the wheelchair.⁶³

33. On August 13, 2007, the resident fell two times on the evening shift, once in her room and once in the day room. No incident reports were completed for these falls. The resident had a 6 by 3.5 cm bruise on her left side. On August 14, 2007, the resident was referred for physical therapy.⁶⁴

34. On August 18, 2007, at 7:00 a.m., the resident was in a wheelchair. She removed the lap buddy and stood up in front of the chair, then her knees buckled and she slid to the floor. The chair alarm was in place, but the incident report does not indicate whether it was sounding. A new intervention of adding tip bars to the wheelchair is noted, which suggests the tip bars had not been added since the previous incident.⁶⁵

⁵⁷ Facility Exhibits Resident #1 (physician order 7/12/07).

⁵⁸ Ex. O-56b.

⁵⁹ Exs. O-32 to O-34; O-35 to O-37.

⁶⁰ Ex. O-57b (Nursing Note 7/19/07).

⁶¹ Ex. O-29.

⁶² Ex. O-59b.

⁶³ Exs. O-38 to O-40.

⁶⁴ Ex. O-62b.

⁶⁵ Exs. O-41 to O-43.

35. On August 19, 2007, at 7:00 a.m., the resident again removed the lap buddy and tried to stand up from her wheelchair. The incident report does not indicate that a position alarm was in place; the new intervention recommended is "chair alarm put in place."⁶⁶ The care plan was amended that day to require the use of a chair alarm and again on August 26, 2007, to require use of a seat belt on the wheelchair.⁶⁷

36. On September 3, 2007, at 1:00 a.m., the resident was found sitting on the floor mat next to her bed.⁶⁸ No incident report was written, and this was not investigated as a fall.

37. On September 13, 2007, at 1:15 p.m. the resident was found sitting on the floor mat next to her bed. She said "I tried to reach my table and landed here."⁶⁹ The bed alarm was sounding. No new interventions were implemented.⁷⁰ A note by the director of nursing dated that day indicates the resident often crawls out of bed and positions herself on her knees with her upper body lying over the bed. She is in a low bed with a contour mattress, floor protection and pressure alarm.⁷¹ On September 17, 2007, the lap buddy was removed and replaced with an alarm belt so that staff would be aware if the resident unbuckled it.⁷² This intervention was not written onto the care plan.

38. On October 4, 2007, at 4:00 p.m. the resident was found lying on the floor mat next to her bed. The bed alarm was sounding. No new interventions were implemented.⁷³

39. On October 15, 2007, the resident was found on her knees on the floor mat next to her bed with her hands folded in front of her on the bed. This was described as a fall in the nursing notes, but no incident report was completed and no new interventions were implemented.⁷⁴

Resident # 14

40. Resident # 14 is an 83-year old man who was admitted to the facility in March 2007 with a recent hip fracture. He is moderately cognitively impaired and has a history of macular degeneration, peripheral vascular disease, and osteoporosis. Upon admission he required extensive assistance with transfers, mobility, and toilet use.⁷⁵ The care plan initially provided that staff would remind the resident of his functional limitations and risk of falling, remind

⁶⁶ Exs. O-44 to O-46.

⁶⁷ Exs. O-29, O-30.

⁶⁸ Ex. O-67a.

⁶⁹ Ex. O-69b.

⁷⁰ Exs. O-47 to O-49.

⁷¹ Ex. O-50.

⁷² Ex. O-70a.

⁷³ Exs. O-51 to O54.

⁷⁴ Ex. O-72b.

⁷⁵ Exs. P-4, P-5 to P-13.

him to call for assistance, and reorient him to the environment and safety measures as needed.⁷⁶

41. On May 5, 2007, the resident was found on the floor after he attempted to transfer himself to the toilet. No new interventions were implemented.⁷⁷

42. On June 24, 2007, the resident was in the courtyard of the facility with family members, who put him in a wheelchair swing. When the swing was pushed, he fell backwards onto concrete and hit his head. In response to this incident, staff members instructed the family on proper use of the swing and the activities manager was to write up an instruction form on use of the swing for residents and family members.⁷⁸

43. On June 27, 2007, the resident fell while attempting to transfer himself from the toilet to a wheelchair. The incident report reflects that a bed alarm was in place. In response to this incident, the facility concluded the resident required both wheelchair and bed alarms.⁷⁹ The care plan was revised to reflect this intervention.⁸⁰

44. On July 3, 2007, at 3:00 a.m., the resident was found sitting on a pad beside his bed after he had tried to get up by himself. The bed alarm was sounding. The incident report states that there was already a mat on the floor next to his bed, although this intervention was not listed in the care plan. No new interventions were implemented, but nursing notes indicate that staff members were to check the resident as frequently as possible.⁸¹

45. On July 16, 2007, at 3:20 a.m., the resident was found on the floor near the nursing station in a large pool of blood. He was bleeding profusely from cuts on his head and face. The resident was transported to the emergency room. He had earlier attempted to get out of bed several times by himself, so staff had put him in the wheelchair and brought him to the area near the nursing station to supervise him. The incident report says the chair alarm was in place, but does not say whether it was sounding or working properly when he fell. The new intervention noted was "seat belt in wheelchair."⁸² This intervention was not added to his care plan until September 12, 2007.⁸³

46. On August 28, 2007, at 1:55 a.m., the resident was found on the floor mat next to his bed. The bed alarm was on and sounding. The incident report reflects that the following interventions were already in place: physical therapy referral, floor mat next to bed, Fallen Angel program, bed/chair alarm implemented, anti-slip shoes/socks. A number of these interventions were not

⁷⁶ P-24.

⁷⁷ Exs. P-29 to P-31.

⁷⁸ Exs. P-32 to P-34.

⁷⁹ Exs. P-35 to P-37.

⁸⁰ Ex. P-21.

⁸¹ Exs. P-38 to P-40.

⁸² Exs. P-41 to P-43.

⁸³ Ex. P-21.

contained in the care plan. The new intervention noted was the possibility of using a seatbelt in the wheelchair, to be discussed at the falls meeting to be held on August 30, 2007.⁸⁴

47. On September 10, 2007, at 3:40 p.m., the resident attempted to get out of his wheelchair to use the bathroom, and the alarm sounded. A staff person got to him before he fell and assisted him onto the floor beside the chair. No new interventions were implemented. A note on the incident report provides that there was a possible need for a seatbelt on the wheelchair, to be discussed at a falls meeting.⁸⁵

48. As noted above, the care plan was revised on September 12, 2007, to require the use of a seatbelt on the resident's wheelchair.

49. On September 18, 2007, at 10:30 p.m., the resident was found on the floor next to his bed. He fell while attempting to get to the bathroom. The bed alarm was sounding. According to the incident report, he had a concave mattress in place prior to the fall (which was not on the care plan). The proposed new intervention was to move his room closer to the nursing station.⁸⁶

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The citation with regard to Tag F323 is supported by the facts and should be AFFIRMED as to scope and severity.

Dated: January 31, 2008.

s/Kathleen D. Sheehy

KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Digital recording (no transcript)

⁸⁴ Exs. P-44 to P-46.

⁸⁵ Exs. P-47 to P-49.

⁸⁶ Exs. P-49 to P-52.

MEMORANDUM

Because falls are among the most common and serious problems facing elderly persons, the Minnesota Department of Health has provided information to health care providers regarding available resources to help health care providers assess and implement interventions for individuals who have a recent history of falls or who are at risk of falls. Falling is associated with considerable mortality, morbidity, reduced functioning and premature nursing home admissions from the community. Incidence rates of falls in nursing homes and hospitals are almost three times the rates for community-dwelling persons over the age of 65. The key concern is not simply the high incidence of falls in older persons, but rather the combination of high incidence and high susceptibility to injury.⁸⁷ The Division issued Tag F323 at severity level 4 (immediate jeopardy), isolated scope. The facility challenges the finding that its practices were deficient as well as the determination of immediate jeopardy.

Tag F 323

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.⁸⁸ The facility must ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.⁸⁹ The intent of this provision is to ensure that the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.⁹⁰

An “avoidable accident” is an accident that occurred because the facility failed to identify environmental hazards and individual resident risk of an accident, including the need for supervision; evaluate/analyze the hazards and risks; implement interventions, including adequate supervision, consistent with a resident’s needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.⁹¹ A “fall” means unintentionally coming to rest on the ground, floor, or other lower level, except as the result of an overwhelming external force (such as one resident pushing another). Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. “Adequate supervision” is defined by the type and frequency of supervision,

⁸⁷ Ex. E.

⁸⁸ 42 C.F.R. § 483.25.

⁸⁹ 42 C.F.R. § 483.25 (h)(1) & (2).

⁹⁰ Ex. G-1.

⁹¹ Ex. G-2.

based on the individual resident's assessed needs and identified hazards in the resident environment.⁹²

Section 483.25 does not make a facility strictly liable for accidents that occur, but it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents.⁹³ A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an adequate level of supervision under all the circumstances.⁹⁴

The Division argues that with regard to all six residents, the facility was or should have been aware of the risk of falls but failed to take adequate steps to prevent them, either because the facility failed to identify environmental hazards and individual accident risks for each resident, including the need for supervision; failed to adequately evaluate/analyze the hazards and risks; failed to implement interventions, including adequate supervision, consistent with a resident's needs; or failed to monitor the effectiveness of the interventions and modify the interventions as necessary. The facility agrees that it could perhaps have done more to prevent falls for each resident, but denies that its practices were deficient.

The record supports the Division's findings of deficient practices, sometimes multiple, for each of the above residents. Most of the time, the facility correctly assessed these residents at the outset as presenting a high risk of falling; and most of the time, the facility adequately investigated these falls by having staff members complete the required incident reports and fall investigation forms. The record reflects, however, that the facility failed to adequately guard against the assessed risks because it failed to provide sufficient individual supervision, failed to adequately analyze the information collected on the fall investigation forms, failed to consistently implement interventions, and failed to monitor the effectiveness of interventions and modify them as necessary. Most if not all of these residents had cognitive impairments that affected their judgment, awareness, and ability to stay safe. It was the facility's responsibility to supervise these residents adequately to mitigate the foreseeable risk that they would fall and injure themselves, and the facility failed to meet this standard.

The facility also argues that the Division improperly found immediate jeopardy with regard to Residents # 6 and 15, contending there was no deficient practice that needed immediate correction and that the facility's interventions had reduced the incidence of falls prior to the survey. Immediate jeopardy is a

⁹² Ex. G-3.

⁹³ *Odebolt Nursing & Rehabilitation Center v. Centers for Medicare & Medicaid*, Docket No. C-04-262 (Dep't App. Bd. Mar. 13, 2007) (<http://www.hhs.gov/dab/decisions/CR1574.html>); *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

⁹⁴ *Id.*

situation in which the provider's noncompliance with one or more requirements of participation has allowed, caused, or resulted in (or is likely to allow, cause or result in) serious injury, harm, impairment, or death to a resident; and this noncompliance requires immediate correction, as the facility either created the situation or allowed the situation to continue by failing to implement preventive or corrective measures.⁹⁵ Only one individual needs to be at risk, and serious harm, injury, impairment, or death does not have to occur before a determination of immediate jeopardy is appropriate; the high potential for these outcomes to occur in the very near future also constitutes immediate jeopardy.⁹⁶

In this case, Resident # 6 did suffer actual harm in the form of a right hip fracture. The facility's interventions were not effective and were not always implemented, nor did the facility revise the interventions appropriately in response to his multiple falls. After the hip fracture, the resident fell again and sustained actual harm (skin tears) when the current interventions were not implemented (position alarms were not properly hooked up). He had two falls during early morning hours when he attempted to reach the bathroom by himself; when the alarms sounded on one occasion, staff did not respond in time to prevent the fall, and when the alarms did not go off on the second occasion staff did not modify the use of position alarms in response to the resident's habit of unhooking them. Reminders to use the call light were clearly an ineffective intervention for a resident who was cognitively impaired and had fallen many times over a period of five months, once with a very serious injury. During the survey, the surveyor observed that the resident's wheelchair alarm was not connected and that he continued to transfer himself without assistance. This is sufficient evidence that the facility's noncompliant practices had caused actual harm in the past and that immediate correction was required to prevent the high likelihood of another serious injury.

Resident # 15 also sustained actual harm in the form of a pelvic fracture and facial cuts. Before this injury the facility had failed to reduce interventions to writing in the care plan, failed to modify interventions when the resident continued to transfer himself without assistance, and failed to use the position alarms properly or monitor them for their effectiveness. In addition, the facility failed to respond to this resident's pattern of falling while attempting to get to the bathroom, by developing an individualized toileting schedule that would reduce his need to attempt these transfers on his own. This resident fell again in September 2007 and sustained a lump and bruise on the back of his head. During the survey, the surveyor observed him transferring himself without assistance, during which time the wheelchair alarm sounded for eight minutes before staff responded to it, because no staff members were present in the nursing wing. Again, this is sufficient evidence to support the finding of immediate jeopardy.

⁹⁵ 42 C.F.R. § 489.3; Ex. G-28 (CMS Interpretive Guidelines for Surveyors).

⁹⁶ Ex. D-1 to D-3 (SOM Appendix Q).

The corrective action plan required the facility to address the systemic issues that created the potential for serious harm, injury, impairment, or death to individuals residing in the facility (staff education and training on monitoring the effectiveness of position alarms, and ensuring staff were present on the unit to respond to alarms), as well as to formulate individualized interventions for the two residents determined to be in immediate jeopardy. The findings of deficient practices and the immediate jeopardy determination should be affirmed.

K.D.S.